Medical Education Services

RESIDENT INFORMATION

LEGAL NAME: _____

First, Middle, Last (specify N/A if no middle name)

CONTACT INFORMATION:

STREET: _____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

HOME PHONE #: _____ **CELL PHONE #:** _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE #: _____

RELATIONSHIP of CONTACT: _____

PERSONAL INFORMATION (mandatory for employment):

GENDER: _____ **DATE OF BIRTH:** _____

(month/day/year)

SIN#: _____

Please be aware that any personal information you share with Nova Scotia Health Authority on this form may be shared, as required, to administer your residency with other organizations such as Maritime Resident Doctors, CMPA, Funding agencies, Dalhousie University, and other organizations. Your signature on this form will constitute consent to share information with the legitimate parties as above.

_____ _____

Resident Signature **Date**